

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

1025863-041359

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED OCT 24 1963

1. PLACE OF DEATH
a. COUNTY

Mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY

Mo.

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

ST. LOUIS

Length of stay in 1b

c. CITY
OR TOWN

ST. LOUIS

Inside Limits
Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

3053 THOMAS ST.

Inside Limits
Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)

3053 THOMAS ST.

Reside on Farm
Yes ☐ No ☐

3. NAME OF DECEASED
(Type or print)

DOROTHY

L. DAWSON

4. DATE OF DEATH
Month Day Year
10 - 11 - 63

5. SEX

FEMALE

6. COLOR OR RACE

NEGRO

7. Married ☐ Never Married ☐
Widowed ☐ Divorced ☒

8. DATE OF BIRTH

8-15-24

9. AGE (last birthday)

39

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

UNKNOWN

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

MISSISSIPPI

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

UNKNOWN

13b. MOTHER'S MAIDEN NAME

UNKNOWN

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

DAVID STEWART 3053 THOMAS ST.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cirrhosis of Liver

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

5810

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I.(a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☒ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

a.m.

Month, Day, Year

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

LUKE JONES

1343 N. GARRISON AVE.

OCT 15 1963

Paul Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO.

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

DATE AMENDED

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Jefferson M. Leaden

Licensed Embalmer No. 5072

P. O. Address 4535 Wacker

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.